ROMANIA FAMILY HEALTH INITIATIVE

Mid-term Project Assessment

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I. EXECUTIVE SUMMARY

Country Context

Throughout Romania access to reproductive health services has been constrained by poor infrastructure, limited management and technical capacity, and restrictive laws and policies. The maternal mortality rate in Romania is the highest in Europe due to abortion and other obstetric complications. Late diagnosis of breast and cervical cancer, and ignorance about risk factors and symptoms, result in Romania having the highest cervical cancer mortality rate in Europe, and a higher than normal mortality rate from breast cancer. The incidence of sexually transmitted infections (STIs), and HIV/AIDS is increasing due to high-risk behaviors, prostitution, human trafficking, and IV drug use.

Prior to 1990, the Romanian government pursued pro-natalist policies and outlawed contraception and abortion. After 1990, abortion was legalized and limited family planning services were developed but due to misinformation and service delivery constraints, abortion remains a significant method for fertility control. Use of modern contraception doubled from 14.5 percent in 1993 to 29.5 percent in 1999 but many couples continue to depend on traditional methods with high failure rates. Data from the 1999 Reproductive Health Survey (RHS) also indicate an increase in knowledge about contraception however large gaps exist between contraceptive knowledge and use. Deeply rooted beliefs and practices among Romanians make the conversion from traditional, unreliable methods of family planning to modern contraception a formidable challenge.

The infrastructure for breast and cervical cancer diagnosis is weak. Mammography is largely unavailable and expensive, and breast self-exam is largely unknown. Only 17 percent of sexually active women in Romania have ever had a Pap smear, and only 12 percent had a test within the past three years.

Romania has undertaken an ambitious program of health reform, but implementation has been difficult and inefficiencies and disjointed services remain. Preventive reproductive health services such as family planning, Pap smear, mammography, and prevention and treatment for STIs, HIV/AIDS, etc. take a backseat to other pressing resource needs for curative care. Remnants of communist-style medicine still exist with centrally planned services, emphasis on specialist medical care, and major inefficiencies. General practitioners, nurse midwives, and nurses are underutilized; care they could easily provide is referred to specialists, often at great inconvenience to patients, especially in rural areas. Lack of sensitivity to patient needs is entrenched within the medical system and there is much work to be done to develop the notion of patient-centered care. Human resources need to be better directed to encourage teamwork to meet the needs of individual patients as well as the patient population at large.

In the last few years the Ministry of Health has recognized the importance of reproductive health and given it higher priority. USAID and other donors have supported various policy, infrastructure, training and service delivery initiatives of which the Romanian Family Health Initiative is one of the most ambitious.

Project Overview

USAID has a cooperative agreement with JSI Research & Training Institute for the purpose of: 1) enhancing primary care to include reproductive health; 2) developing an effective network of reproductive health services; and 3) promoting the use of services. The program, which is called the Romania Family Health Initiative (RFHI), is a partnership of JSI Research and Training Institute (JSI R&T), the Romanian Ministry of Health (MOH) and USAID/Romania. JSI's subcontracted partners are the Society for Education on Contraception and Sexuality (SECS); Population Services International (PSI); Romanian Association Against AIDS (ARAS); Youth for Youth Foundation (YfY); and the East European Institute for Reproductive Health (EEIRH). RFHI began in August of 2001 and ends in September of 2006,

The RFHI contributes to the USAID/Romania Strategic Objective 3.4: Improved effectiveness of selected social and primary health care services for targeted vulnerable groups in Romania. The project's intermediate results are:

IR #1: Improved legal, regulatory and policy framework
IR #2: Improved mobilization, allocation and use of social sector resources
IR #3: Increased access to quality integrated services
IR #4: Citizens better informed about social services, rights and responsibilities

RFHI addresses multiple reproductive health needs including family planning; pre and postnatal care; early detection of breast and cervical cancer; prevention, protocols and referrals for STIs; prevention of HIV/AIDS; and prevention of domestic violence. In order to increase access to reproductive health services, RFHI works on cross-cutting issues such as national policy and resource allocation; public education and behavior change communication; training; quality of care; and sustainability.

RFHI was originally intended to operate in only 10 districts but was quickly expanded to all 42 districts of Romania due to rapid achievements early in the project. The target population of the project is poor women of reproductive age living in rural areas.

Assessment Objectives

This mid-term project assessment was undertaken by USAID (Washington and Romania), JSI R&T (Washington and Romania), the Romanian Ministry of Health, and an independent consultant to:

- Assess the progress toward meeting program objectives at mid-point.
- Assess appropriateness of the project design, and identify factors impeding implementation.
- Advise the USAID/Romania Mission on any needed redirection of the strategy or priorities, which would suggest the modification of the current project approach.
- Assess the appropriateness of the project monitoring and evaluation plan.

The assessment was conducted in Romania, April 19 - 30, 2004.

Major Findings

RFHI has made substantial progress toward achievement of the project goals, i.e., the

intermediate results (IRs) and implementation of activities is on track. The project has been particularly successful in increasing access to family planning services through a varied agenda of policy initiatives, training, behavior change communication, and logistics management. Most family planning outputs have been achieved or even surpassed. Policy initiatives that support a broad package of reproductive health services have been very effective and underlie most of the project's successes.

Activities and outputs to increase access to pre/postnatal care, early detection of breast and cervical cancer, prevention of sexually transmitted infections (STI), HIV/AIDS and domestic violence are not as advanced as those for family planning for several reasons: 1) family planning is the priority intervention for USAID; 2) constraints of the national health system limit the project inputs that can be absorbed for multiple interventions within the project timeframe; and 3) RFHI human and financial resources are insufficient to tackle all aspects of the project simultaneously and with the same level of intensity.

Selected findings include:

- RFHI's technical assistance was instrumental for the development of National Sexual and Reproductive Health Strategy that was adopted by the MOH and disseminated nationally. The strategy, which includes goals and objectives as well as enforcement and implementation mechanisms, is the critical tool for project success.

- The MOH authorized General Practitioners (GPs) to provide family planning services at Primary Health Care (PHC) facilities, a critical factor in increasing access to family planning services. Previously, only GPs with specific training in family planning who work in Family Planning Cabinets located in urban areas were the only providers other than Obstetrician/Gynecologists (Ob/Gyn) who could offer family planning services.

- MOH budget allocations for the National Family Planning Program have increased steadily and substantially over the life of the project.

- Management of contraceptive commodities by national and district authorities has improved due to the development and use of the Logistics Management Information System (LMIS). The LMIS, which has been installed in all 42 districts, allows the DPHAs to track distribution and consumption of contraceptives, and forecast procurement needs.

- Technical assistance provided by RFHI has led to the development of service delivery standards and training curricula for family planning and for pre/postnatal care; preparation of national and district level trainers; and development of supervision check lists.

- More than 2,300 family doctors in all 42 districts have been trained in family planning. As of December 2003, the distribution was:
    - 50% of rural family doctors trained in family planning in16 districts
    - between 20% and 50% of rural family doctors trained in 5 districts
    - between 5% and 20% of rural family doctors trained in 21 districts
- The quantity of contraceptives supplied free of charge or at low cost, measured as Couple Years of Protection (CYP), has at least doubled during each project year

increasing from 65,664 CYP in 2001 to 240,600 CYP as of the end of December 2003.

- The integrated reproductive health services package is too broad to be fully implemented within the project timeframe and resource constraints.
- The LMIS and the "3 Pillars Approach" for service delivery which requires that three essential elements of effective service delivery, i.e., training, commodities and BCC, have been particularly effective and innovative tools that are appropriate for dissemination both nationally and regionally.
- Three contraceptive methods are available from at least one PHC facility in every district, and in most districts there are multiple PHC facilities staffed by a family doctor trained to provide the three methods.
- Interactive training methodologies used by RFHI is widely liked by trainers and training participants.
- Behavior Change Communication (BCC) activities are well integrated in RFHI efforts. The majority of project resources for BCC have been devoted to increasing awareness and promoting use of family planning. RFHI has also supported mass media campaigns for STI/HIV/AIDS prevention.
- Very few resources have been invested in domestic violence prevention activities.
- RFHI has spearheaded the development of a 305 year national BCC Strategic Plan that involves all major organizations working on BCC in Romania.
- Production and distribution of BCC materials is difficult to manage and there have been several occasions when a DPHA has not had sufficient quantities to give family doctors a stock of materials upon completion of training.
- There are anecdotal reports that the number of abortions is decreasing as contraceptive use increases but data are not available to verify those reports.
- The MOH budget allocation for procurement of free contraceptives is unlikely to be sufficient to satisfy increased demand if donor funds are reduced in the future.
- Funding is needed to conduct a population-based survey, which would be the most appropriate and thorough methodology for assessing project impact.

Major Recommendations

Recognizing the significant progress made to date, the assessment team does not recommend major changes in strategies or direction. To accomplish the objectives of the project for reproductive health services other than family planning, RFHI will have to expend more resources (financial and human) for pre/postnatal care, STI/HIV/AIDS prevention, early detection of breast and cervical cancer, and prevention of domestic violence during the latter half of the project. It is nevertheless essential to sustain the momentum for increasing access to family planning services.

Selected recommendations include:

- Maintain family planning as the core of the project's work as other RH services such as pre/postnatal care are increasingly incorporated into project activities in order to assure adherence to USAID's *Guidance on the Definition and Use of the Child Survival and Health Programs Fund 2003* and satisfy the budget "earmark" for family planning.

- Continue to work with the MOH to advocate for policy and regulatory changes that favor the provision of reproductive health services at the PHC and strengthen linkages between the PHCs and FP Cabinets.

- Support MOH advocacy efforts to the NHIH for reinstatement of selected contraceptives as subsidized pharmaceuticals.

- Review the components of the integrated RH service package and set priorities and expected outcomes that are measurable and feasible within the remaining period of the project and with available resources.

- Maximize the use of the FP Cabinets for provider training and technical updates, and strengthen their capacity to serve as referral sites from the PHCs.

- Initiate policy dialog with the MOH for expansion of the contraceptive method mix available at PHC facilities through introduction of new methods such as SDM, procurement of limited quantities of progestin-only pills, and improved referral mechanisms to FP Cabinets for IUD insertion and other methods not available at the PHC level.

- Adapt the LMIS for management of pre/postnatal commodities and BCC materials.

- Test the "3 Pillar Approach" for applicability to pre/postnatal care and disseminate lessons learned.

- Increase the use of mass media to promote the use of family planning services and pre/postnatal care.

- Conduct a training assessment using simple, low cost methodologies to determine whether trainers are able to confidently and effectively use interactive training methods and have mastered technical content.

- Work with district level health promotion staff level for development of BCC programs by providing technical support for conducting formative research, pre-testing messages and methodologies, and evaluating results.

- Strengthen provider skills for interpersonal communication (IPC) and ensure that IPC efforts are closely coordinated with service delivery and capacity-building efforts at the local level.

- Offer technical assistance to the MOH to assess the impact of reduced subsidies on contraceptive use.

- Identify sufficient funds to conduct a final population-based survey to measure coverage of RH services and changes in contraceptive behavior.

II. INTRODUCTION

Country Context

Throughout Romania access to reproductive health services has been limited by poor infrastructure, limited management and technical capacity, and restrictive laws and policies. The maternal mortality rate is the highest in Europe due to abortion and other obstetric complications. Late diagnosis of breast and cervical cancer, and ignorance about risk factors and symptoms, result in Romania having the highest cervical cancer mortality rate in Europe, and a higher than normal mortality rate from breast cancer. The incidence of sexually transmitted infections (STIs), and HIV/AIDS is increasing due to high-risk behaviors, prostitution, human trafficking, and IV drug use.

Prior to 1990, the Romanian government pursued pronatalist policies and outlawed contraception and abortion. After 1990, abortion was legalized and limited family planning services were developed but due to misinformation and service delivery constraints, abortion remains a significant method for fertility control. Use of modern contraception doubled from 14.5 percent in 1993 to 29.5 percent in 1999 but many couples continue to depend on traditional methods with high failure rates. Data from the 1999 Reproductive Health Survey (RHS) also indicate an increase in knowledge about contraception however large gaps exist between contraceptive knowledge and use. Deeply rooted beliefs and practices among Romanians make the conversion from traditional, unreliable methods of family planning to modern contraception a formidable challenge.

The infrastructure for breast and cervical cancer diagnosis is weak. Mammography is largely unavailable and expensive, and breast self-exam is largely unknown. Only 17 percent of sexually active women in Romania have ever had a Pap smear, and only 12 percent had a test within the past three years.

Romania has undertaken an ambitious program of health reform, but implementation has been difficult and inefficiencies and disjointed services remain. Preventive reproductive health services such as family planning, Pap smear, mammography, and prevention and treatment for STIs, HIV/AIDS, etc. take a backseat to other pressing resource needs for curative care. Remnants of communist-style medicine still exist with centrally planned services, emphasis on specialist medical care, and major inefficiencies. General practitioners, nurse midwives, and nurses are underutilized and care they could easily provide is referred to specialists, often at great inconvenience to patients, especially in rural areas. There has been little incentive to be concerned about effective use of manpower and other resources. Lack of sensitivity to patient needs is entrenched within the medical system and there is much work to be done to develop the notion of patient-centered care. Human resources need to be better directed to encourage teamwork to meet the needs of individual patients as well as the patient population at large.

In the last few years the Ministry of Health has recognized the importance of reproductive health and given it higher priority. Recognizing that, USAID and other donors have supported various policy, infrastructure, training and service delivery initiatives of which the Romanian Family Health Initiative is one of the most ambitious.

Project Overview

The Romania Family Health Initiative (RFHI), a Cooperative Agreement between USAID and JSI R&T, started in August of 2001 and will end in September of 2006. RFHI is an "umbrella" for multiple activities that were previously implemented under separate projects. RFHI is a partnership of JSI R&T, the Romanian Ministry of Health (MOH) and USAID/Romania which launched the Initiative. It is implemented by JSI and its partner organizations including: Society for Education on Contraception and Sexuality (SECS); Population Services International (PSI); Romanian Association Against AIDS (ARAS); Youth for Youth Foundation (YfY); and the East European Institute for Reproductive Health (EEIRH). RFHI has developed agreements with other Romanian organizations, i.e., the National Union of People Living with AIDS (UNOPA), the Institute for Health Research and Development, Soros, Renastera and others to implement specific programs and pilot activities. District level activities are conducted in collaboration with the District Public Health Authorities (DPHA).

The RFHI contributes to the USAID/Romania Strategic Objective 3.4: Improved effectiveness of selected social and primary health care services for targeted vulnerable groups in Romania.

The project's intermediate results are:

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RFHI addresses multiple reproductive health needs including family planning; pre and postnatal care; early detection of breast and cervical cancer; prevention of STIs and HIV/AIDS; and prevention of domestic violence. In order to increase access to reproductive health services, RFHI works on cross-cutting issues such as national policy and resource allocation; public education and behavior change communication; training; quality of care; and sustainability.

Due to early project success, RFHI, which was originally intended to work in only 10 districts, was quickly expanded to all 42 districts of Romania. The project's focus is on rural areas based on a strong correlation that exists in Romania between poverty and rural residence. Of the 45 percent of Romanians are considered to be poor or near poor, 29.5 percent of them live in rural areas. Thus, rural women of reproductive age who are poor or near poor are the main beneficiaries of the RFHI.

Assessment Objectives

As defined in the Statement of Work, the purpose of the mid-term project assessment was:

- To assess the progress toward meeting program objectives at mid-point.
- To assess appropriateness of the project design, and identify factors impeding implementation.

- To advise the USAID/Romania Mission on any needed redirection of the strategy or priorities, which would suggest the modification of the current project approach.
- To assess the appropriateness of the project monitoring and evaluation plan.

Assessment Methodology

The assessment was conducted in Romania during a two-week period, April 19 - 30, 2004. The team included an independent consultant (team leader), representatives of USAID/Romania, USAID/Washington and the Ministry of Health, JSI staff of the RFHI and JSI staff from headquarters. A list of questions to be addressed by the assessment was prepared by USAID as part of the overall Statement of Work (SOW) and a schedule for the assessment team's visit to Romania was prepared by JSI and USAID staff. (See Annex 1)

To respond to the predetermined assessment questions, the team collected information using the following:

- Review of documents
- Presentations
- Meetings with stakeholders
- Site visits in Bucharest, Cluj and Dolj
- Interviews with RFHI staff, DPHA members, health providers

III. ASSESSMENT FINDINGS AND RECOMMENDATIONS

The findings and recommendations of the assessment team are presented in this section and organized according to the major headings of the questions in the Statement of Work. Findings are written in narrative form; recommendations are indicated with an arrow symbol ? .

1. Project's Progress Toward Project's Goals

RFHI has made substantial progress toward achievement of the project goals, i.e., the intermediate results (IRs), due in large measure to the leadership of the project and to the professionalism and dedication of the staff.

Implementation of activities and the achievement of results for family planning are on track or in many cases have surpassed expected outputs. Policy initiatives that support a broad package of reproductive health services have been very successful.

Activities and outputs to increase access to pre/postnatal care, early detection of breast and cervical cancer, prevention of sexually transmitted infections (STI), HIV/AIDS and domestic violence are not as advanced as those for family planning for several reasons: 1) family planning is the priority intervention for USAID; 2) constraints of the national health system limit the project inputs that can be absorbed for multiple interventions within the project timeframe; and 3) RFHI human and financial resources are insufficient to tackle all aspects of the project simultaneously and with the same level of intensity.

USAID/Romania's strategic objective of "increased effectiveness of selected social and

primary health care services for targeted vulnerable groups in Romania," is interpreted in the RFHI program description as "increased access to quality family planning and other integrated reproductive health services, especially to rural poor and to other selected vulnerable groups, including Roma and urban poor." The indicator of the key project result is the contraceptive prevalence rate (CPR), which can only be measured after the end of the project using a population based survey. However, the annual proxy indicator, Couple Years of Protection (CYP) supplied free of charge or at low cost, has at least doubled during each project year increasing from 65,664 CYP in 2001 to 240,600 CYP as of the end of December 2003.

RFHI has had a number of successes in the regulatory and policy arena (IR 1). To create an enabling environment, RFHI instituted a year-long consensus building process among key stakeholders that resulted in the adoption of a National Sexual and Reproductive Health Strategy. The strategy was endorsed by the World Health Organization (WHO), printed and disseminated during a national conference, "Family Planning in Romania: From Strategy to Best Practices" held in March 2003. This comprehensive reproductive health legislative and regulatory package with appropriate reinforcement and implementation mechanisms is the critical tool for achieving project objectives of the three other IRs. RFHI's primary role under IR 1 is to facilitate communication and provide technical information for various policy and regulatory bodies to ensure development of technically sound and appropriate policies and standards.

A significant policy change that occurred as a result of RFHI advocacy and policy efforts is the authorization by the MOH of General Practitioners (GPs) to provide family planning services at Primary Health Care (PHC) facilities. Previously, only GPs with specific training in family planning and who work in Family Planning Cabinets located in urban areas were the only providers other than Obstetrician/Gynecologists (Ob/Gyn) who could offer family planning services. The authorization of the PHC physicians as providers of family planning and other reproductive health services has been essential to the success of the project.

Other important policy achievements to which the RFHI contributed:

- Guidelines for family planning services were drafted in close collaboration with MOH/MCH Unit department. The WHO recommendations for contraceptive use were translated into Romanian and were included as references in the MOH National FP program and were used in basic FP training for PHC providers.
- Guidelines for pre/post natal care service provision in PHC were developed in consultation with the Institute of Mother and Child Health, DPHA representatives and PHC providers.
- Other policy barriers that were overcome by Ministerial or Governmental decisions: provision of FP and pre/post natal care services for uninsured people; free STI treatment and testing for uninsured and high risk populations; transfer of abortion services into ambulatory units.
- The strategy for STI prevention was adopted by the government.

IR 2 (improved mobilization, allocation and use of social sector resources) is considered by JSI to be critical for assuring the sustainability and effectiveness of integrated RH services throughout Romania. RFHI has provided technical assistance and training to

strengthen the management capacity within the MOH. It is anticipated that improved management of planning and budget functions will instill confidence and attract more resources for primary health care from the Romanian government and donor agencies alike.

RFHI organized national-level workshops and seminars to spearhead policy discussions on important PHC resource allocations and other resource mobilization issues. MOH budget allocation for family planning under National Program (NP) #3, has increased continuously during the project. In 2002, the MOH allocated $530,000 for the National Family Planning Program, which was 5 times more than the amount spent in 2001. In 2003 the amount was $663,000, representing a 25% increase over 2002 expenditures; and in 2004 an unprecedented $1 million was allocated. The funds were used to procure contraceptives to be distributed for free to the uninsured population. In addition to annual increases for contraceptive procurement, in 2003 the budget for reproductive health programs implemented in PHC facilities (e.g., family planning, pre/postnatal care, breastfeeding management and promotion) was increased by 10 percent to $2,887,000 which is approximately 43 percent of the total budget of the NP#3.

RFHI efforts to improve the management capacity of the District Public Health Authorities (DPHA) also show positive results. At the end of 2002 only a few DPHAs developed work plans for the year 2003 and those that were developed were not sent to the national MOH but were used by the districts to monitor cash flow and expenditures between different sub-programs. By the end of 2003, the 18 DPHAs that had been assisted by the RFHI up to that point developed work plans for NP3 interventions and sent them to the MOH/MCH Unit and Program Management Unit for budget preparation and allocation. to build up the budgets of the NP3 for the year of 2004. The overall need of NP 3 was about $30 million, but only $23.5 million were approved by the Ministry of Finance. Nevertheless, this represents a 25 percent increase as compared with the budget of NP3 for 2003.

Another important contribution by the RFHI for improved management by national and district authorities is the development and implementation of the Logistics Management Information System (LMIS), a tool for managing contraceptive commodities. Using the LMIS, DPHAs can track distribution and consumption of contraceptives, and forecast procurement needs. The result is fewer shortages of contraceptives in clinics, and less wastage of products that have exceeded their shelf life. The LMIS also facilitates reporting quarterly CYPs by the DPHAs to the central MOH. By the end of 2002 installation and training for use of the LMIS was implemented in 18 districts and by late 2003 the system had been rolled out to all 42 districts. The result of the LMIS is improved reporting: 97 percent of DPHAs submitted their 3rd quarter report on time by the end of October 2003.

Despite the project's achievements under IR 2, mobilization and allocation of resources are issues that are generally beyond the scope of the project and should be addressed by initiatives dedicated to health sector reform and health care financing.

RFHI has made significant progress under IR 3 (increased access to quality integrated services) particularly for family planning. The end of project target calls for 1640 family

doctors (GPs) to be trained in integrated basic RH services.[1] Although 2300 family doctors have been trained in family planning, only 920 doctors are counted as trained according to the weighted calculations (see footnote 1). As of December 2003, the distribution of family doctors in rural areas trained in family planning was:

- 50% of rural family doctors trained in FP in 16 districts
- between 20% and 50% of rural family doctors trained in 5 districts
- between 5% and 20% of rural family doctors trained in 21 districts

Other achievements under IR 3 include development of curricula for family planning and pre/postnatal care; training of national and district level trainers for family planning; and development of supervision check lists for family planning. As stated previously, CYP from free and socially marketed contraceptives has more than tripled since the start of the project.

It is clear that the achievements in increasing access to family planning services in rural areas have been made possible by the policy changes achieved under IR 1 and increased resource allocations achieved under IR 2.

BCC programs are well integrated in the RFHI efforts. Under IR 4 (citizens better informed about social services, rights and responsibilities), RFHI has conducted BCC campaigns in key RH areas. Measurement of the key IR indicator (women who are knowledgeable about RH) is not possible until the end of the project using a population-based survey. IR 4 will be discussed in more detail in other sections of this report.

2. Project Design and Implementation

The RFHI is an ambitious project that includes several technical interventions and multiple cross-cutting issues. Several members of the assessment team were concerned that the breadth of the integrated RH services package is too broad to be successfully implemented within the project timeframe and resource constraints. RFHI staff are committed to addressing the full package of integrated RH services, although they concede that activities are likely to be limited to helping develop national strategies rather than strengthening PHC service delivery capacity for services such as early detection of breast and cervical cancer, STI diagnosis and treatment, and prevention of domestic violence. RFHI has neither the financial resources nor the time needed to implement the step-by-step processes required to make such services available at the PHC facilities. Other constraints to making such services available in rural areas include the lack of laboratories, technicians, equipment and supplies needed for screening, all of which are far beyond the scope of the RFHI. As well, family doctors do not have the equipment or the clinical skills needed to collect samples, and there are few professionals in rural areas that are trained to intervene in cases of domestic violence. Additionally, insurance reimbursement and fee for service mechanisms do not currently provide sufficient incentive for family doctors to take on an ever-expanding program of services such as cancer screening.

[1] For monitoring and evaluation purposes, USAID/Romania defined "integrated reproductive health services" and assigned weights as follows: family planning = 40%; pre/postnatal care = 25%; STI screening = 15%; early detection of breast and cervical cancer = 20%.

The assessment team supports maintaining the integrated RH package with the caveat that the activities to be undertaken and the expected outcomes are clearly defined and agreed upon with USAID.

- The team recommends that JSI and USAID review the components of the integrated RH package and set priorities and expected outcomes that are measurable and feasible within the remaining period of the project, with available funds and given the constraints of the Romanian health system that are beyond the scope of the RFHI.

JSI and the RFHI partners have invested considerable time and effort setting out a realistic and practical plan of action for the project. RFHI partners (including USAID and the MOH) developed a strategic framework at the outset of the project and a comprehensive monitoring and evaluation plan. Annual work plans are jointly developed and, based upon the annual work plan RFHI prepares quarterly and annual reports that demonstrate progress/lessons learned to date as well as outlining challenges and issues that have hindered program implementation. All RFHI partners plan and report on activities and monitoring of indicators.

Planned activities to achieve project objectives and goals are appropriate and demonstrate the sequential steps that must be taken to implement a project of such breadth. For example, implementation of family planning training had to be preceded by policy initiatives authorizing family physicians to provide family planning services; development of national family planning standards and protocols; preparation of a family planning training curriculum; and training of national family planning trainers. Only with these in place, could the project proceed to selection of trainees and conduct of training. Similar steps must be taken for each of the technical interventions, which are time-consuming and require agreement from many different quarters. Opposition or disagreement among the various players can cause delay or may even derail initiatives. For example, some ob/gyn specialists were opposed to authorizing family doctors as RH providers citing concerns that GPs do not have the clinical training needed to provide quality services. Overcoming that opposition required concerted evidence-based advocacy efforts. And in developing standards and protocols for family planning and pre/postnatal care, RFHI staff had to strike a balance between national practices and international evidence-based recommendations.

In terms of the overall administrative and implementing structure, RFHI has carried out strategic planning, and the development of a M&E plan and annual work plans responsive to the cooperative agreement in collaboration with key partners (MOH, subcontractors). Participatory planning has resulted in a transparent and sustainable approach for the design and implementation of the RH program in Romania. Additional partners are selected, according to their technical area and capacity, to take part in various levels of project planning. JSI develops annual budgets and has forecasted the stages of major program implementation over a five year time period. Routine financial oversight is provided by JSI/U.S., and program management support is also routinely given by JSI/U.S. JSI/Romania submits its deliverables (work plans, quarterly reports) on a timely basis to USAID/Romania and provides the Mission with any additional information, technical or administrative, as requested. JSI/U.S. carries out an annual client satisfaction survey with its major partners, USAID/Romania and the MOH, to assure that the project is responsive to both technical and management components of the project.

JSI carefully selected its subcontractors at the outset of the project. Other NGO partners have been brought in depending upon a specific need for a technical, program or particular population focus. The project has a full staffing pattern with both professional technical and administrative staff. Each of the technical staff is responsible for a key program and/or technical area, e.g. policy, service delivery, BCC, training, youth, etc.

The project places great importance on regular and effective communications with its partners, in particular with USAID and the MOH. The project through leveraging of resources has been successful in achieving its cost sharing responsibilities in this cooperative agreement.

RFHI and USAID have a collaborative relationship and the project has benefited from the active support of the USAID Health Officer as well as with the Mission Director. There is continuous dialogue and sharing of information, especially around the areas of planning and policy development.

The assessment team found several examples of tools and approaches that are appropriate for roll-out and replication in Romania and for dissemination to other countries of the East European region. The Logistics Management Information System (LMIS), developed for management of contraceptive commodities, can track distribution and consumption of supplies, and forecast procurement needs. The result is fewer shortages of contraceptives in clinics, and less wastage of products that have exceeded their shelf life.

The other example is the "3 Pillar Approach" for service delivery which requires that three essential elements for effective service delivery, i.e., training, commodities and BCC, are addressed from the outset. The 3 Pillars Approach has been effective in ensuring that: 1) providers are trained in family planning; 2) trained providers have contraceptives to distribute; and 3) that there is client demand for services. Presentations about the approach have been made at regional and international conferences.

- Continue to disseminate the LMIS and the 3 Pillar Approach at regional and international seminars and conferences and through publications and web sites.

3. Project Implementation Elements

a. Service Delivery

At the project mid-point, the bulk of project activities in general and all service delivery activities in particular have been dedicated to family planning. Services for pre/postnatal care are in the process of being developed; thus far standards and protocols have been developed and a training curriculum has been prepared. Service delivery will be rolled-out on an incremental basis as family doctors are trained. (It should be noted that many family doctors already offer pre/postnatal care according to the protocols in place at the time of their medical education.)

The LMIS was developed for contraceptive management but as the pre/postnatal care

component of the project is implemented, RFHI is planning to integrate additional supplies such as iron+folate tablets and tetanus toxoid vaccine into the LMIS.

RFHI has supported development of provider skills through family planning training, technical updates, and supervision. The project has also tried to improve referral mechanisms across the various tiers of the health system by meeting with representatives of different tiers, and by using them for training and supervisory functions. Supervision checklists have been developed and supervisory visits conclude with written feedback to providers, with the aim of improving quality of care and strengthening skills.

To increase access to services for the rural poor who make up the majority of the Romanian population, RFHI has concentrated on developing the service delivery capacity of the PHC facilities in rural areas. However, RFHI has also provided training and LMIS to the Family Planning Cabinets that are usually attached to a polyclinic in a town or city. To ensure adequate access to services, both the FP Cabinets and the PHC facilities must function within an integrated framework of services available at all levels of the health system. The framework should include a detailed description of the services provided at each level with key roles, responsibilities and referrals across the Romanian health system including facility-based services provided by Ob/Gyn and other specialists, Family Planning Cabinets, and Family Doctors as well as community-based services provided by community nurses and Roma mediators. Within that framework, the Family Planning Cabinets have an important function in supporting the Family Doctors, providing complementary services and increasing access to an expanded method mix (e.g., IUDs).

- Maximize the role that FP Cabinets play in project activities such as provider training and supervision, and strengthen their capacity to serve as referral sites from the PHCs.

The quality of clinical and counseling services for family planning could not be determined by the team as services were not observed: Time allotted for clinic visits and the assessment methodology were not adequate for this purpose. However, periodic supervision visits using a checklist provides for a review of client records to check whether WHO eligibility criteria are followed. The quality of counseling is very difficult to assess among the Family Doctors who are widely dispersed and have low daily volume of family planning clients. Comments made by the providers interviewed by the team indicated an appreciation for client choice and the importance of communication between providers and clients but whether providers put these principles into practice could not be verified. Direct observation, client exit interviews and “mystery clients” are techniques to assess counseling quality but are not feasible for the RFHI due to low client volume as well as the complexity and cost of such survey techniques.

The method mix of free contraceptives available at PHCs is limited to three methods: injectables, combined oral contraceptives, and condoms. The availability of these methods at multiple PHC facilities in the 42 districts represents a huge improvement in access to family planning for a substantial proportion of the Romanian population. Continuing to increase access to these methods through training of additional family doctors in other facilities is planned. Quality improvements could also be achieved by further expansion of the method mix. For example, adding progestin-only pills would provide an appropriate method for women who prefer pills but cannot use pills containing

estrogen because of medical conditions or breastfeeding. The Standard Days Method (SDM) will be introduced in selected areas and will provide an option for clients who prefer to use a natural method. Improved referrals to the FP Cabinets could increase access to IUDs.

- It is recommended that RFHI work with the MOH to expand the contraceptive method mix available at PHC facilities and to improve referrals to the Family Planning Cabinets for clients that want methods such as IUDs that are not available at the PHCs.

The assessment team only visited three PHC facilities but improper disposal of used needles and syringes was evident in all of them indicating that more attention to infection prevention (IP) procedures during training and supervision visits is warranted. Compliance with IP procedures is an essential element of quality of care for all health services, not just reproductive health. Programs supporting health system improvements such as RFHI should use all available opportunities to reinforce IP guidelines thereby improving the quality of care and protecting providers and clients alike.

- Review all training and supervision materials and strengthen content for infection prevention including hand washing, proper use and treatment (either decontamination or disposal) of gloves, proper decontamination of instruments, and proper disposal of medical waste. RFHI should work with DPHAs to ensure that burn pits are not accessible to animals or people and that cleaning staff have heavy duty utility gloves and adequate footwear.

The assessment team interviewed eight family doctors. All those asked whether they discuss family planning with prenatal clients responded affirmatively. The counseling curriculum integrates FP into various components of RH - with pregnant and postpartum women, with post-abortion clients, etc. The training in FP technology covers appropriate methods for postpartum and post-abortion women. Dual protection is presented in training sessions about condoms, as is how to talk about safe sex and responsible sexual behavior with clients, especially those at 'high risk' of STIs.

b. Training

The assessment team did not observe any training sessions and as noted above, the team did not observe counseling or clinical services or have other opportunities to assess provider competence gained from training. Therefore, the team cannot determine whether training done by RFHI is adequate.

RFHI has used eight trainers that were trained during previous projects as "master trainers" and provided them with additional skills development in training methodology. These master trainers have trained district-level trainers. RFHI staff are aware of varying levels of competence among the national and district trainers and would like to assess the quality of training and impact on services. Although training participants are always asked to complete an evaluation form at the conclusion of training workshops, these evaluations provide RFHI with subjective data about whether participants found the workshop useful, what they liked/disliked, etc. Complementing these evaluations with a training assessment that would provide objective data on training competence (including use of training methodologies and mastery of technical content) would offer useful information to improve future training.

- Conduct a training assessment by in-country staff using simple, low cost methodologies.

All of the trainers and trained providers with whom the team met said that they liked the interactive training methodology used during RFHI training. Several mentioned that the participatory nature of the training helped them absorb and retain information better than traditional lectures.

The direct impact of training on service delivery cannot be measured, but indirectly, the contraceptive prevalence rate and the number of contraceptives distributed (or CYPs) can be seen as measures of impact of the training on access and use of services.

c. Behavior Change Communication (BCC)
BCC programs are well integrated in the RFHI efforts. Up to this point the focus for BCC has been on information and the provision of printed materials, plus some mass media campaigns. Health Promotion (HP) has not been closely linked with services. JSI introduced the idea of BCC, and advocated for a stronger focus on Interpersonal Communications (IPC), an approach that has been accepted. The task now is to tailor all BCC activities to match this approach.

Most of the project's BCC resources (financial and human) have been focused primarily on increasing awareness and promoting use of family planning. Efforts and investments to date have focused on training several cadres of providers and promoters, and on assisting with the distribution of materials during community meetings, factory presentations, and counseling sessions. To complement MOH efforts, the project has provided modest local BCC support to the campaign associated with the introduction of free contraceptives. Promotion of family planning services has emphasized IPC approaches rather than media campaigns. In later stages of the project, when all or most family doctors have been trained and are providing services, the role of mass media could be expanded, at least by using media at local level. In 2004, the RFHI intends to design and implement a model IPC approach, in a well-defined geographic area, which makes more effective use of all available local human and financial resources for HP efforts, including district HP staff, the family doctors, nurses, community nurses, mediators and NGO volunteers.

- Focus on IPC, particularly for family planning, ensuring that IPC efforts are closely coordinated at the local level with service delivery and capacity-building efforts. It is also important that the various IPC mechanisms be used in a coordinated manner.

- In the future, increase the use of mass media to promote use of family planning services and pre/postnatal care.

RFHI has supported a series of campaigns about HIV/AIDS/STI carried out by the project partners. These campaigns have used a variety of media – including mass media -- and IPC approaches at the national and the district level. Target groups have included adults and youth, with messages intended to raise awareness and knowledge and reduce discrimination. Due to the target audience and the specificity of messages being transmitted, RFHI concentrated on the use of mass media for HIV/AIDS/STI campaigns rather than IPC.

To date the project has devoted only minor resources to domestic violence through support to local campaigns. However, more groundwork on policy (and services) is needed for BCC campaigns to be more effective.

- RFHI resources for domestic violence should be devoted to policy initiatives rather than BCC in order to be most effectively applied.

All project activities, including BCC, are planned and implemented with close collaboration of national and district level officials. That said, the capacity and leadership of the health promotion function in the MOH is rather weak. However, a number of local NGOs are positioned to play major supplementary roles. Effective collaboration and the use of these valuable resources have been slowed down by the contrasting expectations of the MOH and the other stakeholders. JSI has been working to facilitate greater collaboration within the public sector, and between the public sector and the NGOs. To advance progress, JSI has drafted a 3-5 year BCC Strategic Plan, which will involve all key organizations. This draft plan will need to be discussed and negotiated by all partners in order to move ahead. A major issue that needs to be negotiated involves practical financial mechanisms for allocating funds for local activities, whether via NGOs, or via local authorities. One option that might be feasible would be for the GOR to consider contracting out some BCC functions to qualified local NGOs, an approach that has worked successfully in other countries.

- RFHI should work with the MOH to determine an appropriate division of labor among the capable organizations in order to create synergies and increase impact. The project should also try to assist health promotion officials within the MOH to invest in and strengthen the public HP network and foster collaboration with NGOs.

RFHI has ensured that all materials produced by the Project are replicable at low cost even during the life of this project, and has leveraged national and donor funds outside RFHI resources, especially FP leaflets and posters. For example, in 2003 the Project helped to leverage substantial funds from UNFPA and the MOH to print family planning materials.

Looking beyond the project, in order to create meaningful and sustainable BCC programs at the local level, it is essential that local health promotion (HP) resources be identified and strengthened to plan and implement their own programs. Currently, however, these local HP resources (actual and potential) lack the skills, resources, and encouragement to play these roles. They need assistance to develop a "partnership building process" at the local level. Since this is a relatively new and untried idea, approaches should be developed and tested in a set of pilot districts.

- Work with district level health promotion staff to develop local BCC programs by providing technical support for conducting formative research, pre-testing messages and methodologies, and evaluating results.

All providers are supposed to receive a stock of IEC/BCC materials at the conclusion of their training although on several occasions a DPHA has not had sufficient quantities of materials at the time that training ended. The stock of IEC/BCC materials at PHC facilities is assessed and noted on the supervision form. SECS and DPHA staff have found stock outs or insufficient quantities of materials at PHC facilities but data for the frequency of such shortages have not been analyzed. Despite the considerable amount

that has been spent on printed materials, the quantity is never enough. To rectify this situation the Project needs to work with the MOH to develop and implement a "materials security" approach, including projection method for materials, plus their distribution and tracking of consumption, to ensure continuous availability. This system would also provide the basis for longer term budget needs.

- Proceed with plans to design a LMIS for printed materials that facilitates projections for needed amounts of materials, continuous supply, and estimated budget needs for printing and distribution. Project staff need to determine the feasibility of integrating a print materials LMIS with the existing commodities system.

In Romania to date there has been little attention paid to the use of community dynamics to change behaviors, to create and sustain demand, dispel negative rumors, and generate community resources for PHC. Discussions with HP leaders in Romania indicate that Romanian health authorities are interested in learning more about the feasibility of such an approach. Key issues that will need to be addressed include: who would have the time, ability and interest to play the role of community mobilization coordinator; whether the community will respond and support this approach; and whether local authorities would provide the needed support and encouragement.

- A low-cost pilot effort should be developed to determine the feasibility and effectiveness of community mobilization strategies. Possible criteria for selecting pilot districts could include: a capable and committed district HP leader; a "complete" number of trained providers; and, the willingness of these various stakeholders to work together.

Efforts to work with journalists, while modest, have produced good results. RFHI has conducted seminars to help journalists better understand reproductive health issues, and to correct myths and misinformation.

- RFHI should consider expanding its focus to journalists at the district level.

RFHI has invested considerable effort in IEC/BCC activities. Impact of IEC/BCC and other activities will be measured using a population-based survey toward the end of the project life. RFHI currently uses proxies, e.g., media recall surveys (quantitative Omnibus surveys), media monitoring reports, and focus groups with the target population on message recall and self perceived knowledge increase, after BCC interventions. The project has very little evidence, however, about service utilization as a result of those interventions. To make sound decisions about how to invest project resources, RFHI needs to know what messages, methodologies and media are most effective for increasing service utilization and sustaining healthy behaviors.

- Strengthen efforts to evaluate current and future BCC activities. Given the budgetary constraints, perhaps the best approach would be to seek out relatively simple, low-cost evaluation methods or approaches that can meet project needs.

d. NGO Involvement

NGO partners of the RFHI has been actively involved in all aspects of the project, from developing the strategy framework and M&E plan, to preparing annual work plans, to planning and implementing various activities. SECS is the largest and most influential NGO working in family planning in Romania and is RFHI's main partner for training

activities. In addition to training, SECS provide technical assistance to develop supervisory capacity at the DHPAs.

RFHI has been extremely successful in identifying appropriate NGOs for a technical intervention or activity and has fostered networking and alliances among several NGOs working in a given program area. In addition to their roles as providers of technical assistance to the MOH, RFHI has sought to assist the partner NGOs to be become more sustainable. To this end, JSI has provided training in business development including how to access funding from other donors, proposal writing, developing monitoring and evaluation plans/indicators, and sustainability development. RFHI carries out joint annual work planning, ongoing assessment of activities, reporting and monitoring and evaluation with all of the key NGO partners. There are several levels of NGO involvement in the RFHI: five NGOs are subcontractors; several other NGOs have been or will be funded to carry out specific interventions under RFHI.

- Provide assistance to SECS for business planning and development of a marketing plan and strengthen training and technical support to increase sustainability of the partner NGOs.

e. Family Planning

Although RFHI is designed to address "integrated basic reproductive health services" family planning is the core of the project. Among the RH services included in the integrated package, family planning is assigned the highest weight in the M&E plan. And as of the project mid-term, project activities and achievements in policy, resource mobilization, training, BCC, logistics management, service delivery, etc. have been predominantly related to family planning and over 80 percent of project funds were devoted to family planning objectives.

RFHI activities to make family planning services accessible to the rural poor and to promote their use are implemented within the context of improving reproductive health. RFHI's BCC and service delivery strategies do not specifically promote family planning as an alternative to abortion but several family doctors said that among their clients, the number of abortions is decreasing as contraceptive use increases. However, data are not available to verify such anecdotal reports. To more fully respond with U.S. Congressional interests, more emphasis needs to be placed on documenting these reports.

- As other RH services such as pre/postnatal care are increasingly incorporated into project activities, RFHI should maintain family planning as the core of the project's work in order to respond with U.S. Congressional interests in lowering the abortion rate in the E&E region as well as to satisfy the "earmark" for family planning and assure adherence to USAID's *Guidance on the Definition and Use of the Child Survival and Health Programs Fund 2003.*

A potential threat to continued expansion of FP services is the limited supply of free contraceptives which may not satisfy increased demand. The MOH budget allocation of $1 million for procurement of contraceptives for free distribution is not expected to increase anytime in the foreseeable future. Thus, the MOH may face a challenge in satisfying the growing demand for contraceptives. The MOH expects to impose more rigorous criteria for receipt of free contraceptives, which will make many current users ineligible for free commodities in the future. RFHI is already working with the MOH on

contraceptive security, however, greater attention is needed for strategies to more effectively target subsidies and to increase cost reimbursements.

- RFHI should offer technical assistance to the MOH to assess the impact of eventual reduction of subsidies on contraceptive use and to plan strategies to identify alternative mechanisms to ensure contraceptive security.

Compounding the likely shortages of free contraceptives is the decision of the National Health Insurance House in 2003 to withdraw contraceptives from the list of subsidized pharmaceuticals. Lack of subsidized contraceptives would push consumers who cannot afford commercial brands to try to obtain free commodities or possibly to discontinue family planning use.

f. Gender Balance and Equity

RFHI has not made a concerted effort to include men in BCC or service delivery activities. Indeed, the target population of the project is defined as poor women of reproductive age living in rural areas. Men are not completely excluded, however: Training in family planning counseling includes counseling for women and couples. Activities to increase knowledge about STI/HIV/AIDS prevention and promote condom use have been aimed at both men and women. ARAS, an NGO partner, is implementing the only training that is specifically for men. The training is conducted among men in prison and is focused on reducing risk of STI/HIV/AIDS transmission.

- Given RFHI's very full agenda of continuing to expand family planning services, roll out training and service delivery activities for pre/postnatal care, develop awareness-raising activities for early detection of breast and cervical cancer, and continue public education about STI/HIV/AIDS prevention, it is recommended that the project continue to focus primarily on women of reproductive age.

g. Youth

RFHI works with a local NGO, Youth for Youth (YfY), on activities geared toward young people. With project support, YfY has set up a clinic in Bucharest that may provide a model for the MOH to replicate. RFHI's family planning training curriculum has been used to train school doctors who work with youth.

The project has undertaken several BCC efforts designed to reach youth including:

- Youth Centers which provide FP services, including counseling and referral for other RH-related areas;
- Summer campaigns focusing on dual protection (condom use for protecting against unwanted pregnancies and STIs) done in places where youth spend holidays (beach resorts, camps), and using youth volunteers trained as peer educators.

- It is recommended that USAID increase its assistance in the area of youth and reproductive health. Increased knowledge about reproductive health and adoption of healthy behaviors by youth will have long-term benefits for individuals and the country as a whole.

h. Host Government Involvement

RFHI has established a very collaborative relationship with the MOH, including officials within the NP#3 and the Program Management Units of NP#1 and #3, the DPHAs and their field staff. A concerted effort was made to develop a cohesive and integrated team approach with the MOH (as well as other Ministries) to promote sustainability of project initiatives and results. RFHI is process-oriented, which means that planning and program development are subject to intensive discussions, consensus and collaboration among all parties. This approach can be time consuming and slow, but has yielded dividends in the form of strong MOH support for project goals, coordinated objectives and activities among multiple organizations, leveraging of donor resources, increased participation of NGOs, and strengthened capacity across all parties.

Although there has been a frequent turnover of decision-makers in the MOH (5 Ministers of Health over the last 12 months), the RFHI receives strong support from the highest levels within the government, including the Prime Minister Health Advisor, Minister of Health (over a two year period), and the Director of the MCH Department and PHC. The project works closely with the Directors of NP#1 and #3 and their staff. USAID, MOH and JSI meet regularly to review project status, discuss future program implementation and address challenges and opportunities facing project implementation.

Since the start of the project, RFHI has provided technical support to the MOH for contraceptive procurement. RFHI staff worked with MOH officials for forecasting, comparative costing, rules and regulations, competitive bidding, and procurement processes which resulted in a cost savings of over $700,000 for the MOH. Not only was the MOH pleased with the cost savings but officials have a better grasp of the country's contraceptive security needs, and there is more in-house knowledge about commodities procurement.

In addition to the MOH, RFHI has also worked with the Ministry of Education, the Ministry of Youth, and the Ministry of Labor and Family for RFHI activities of school RH, youth-oriented services, and domestic violence.

- To increase capacity building efforts for the Program Management Unit (PMU) of National Program #3 (MCH), PMU staff should be trained by JSI and SECS to take full responsibility for the management of contraceptives and data. Training from the DELIVER Project and other technical assistance will need to be provided, reinforced by supervision and followed closely by JSI and SECS.

i. Coordination with other USAID Projects and Donors

RFHI is committed to initiating and maintaining strong coordination mechanisms with donors within Romania, the Region and Europe. JSI has been included in the Romanian Donors meeting held regularly by the Ministry of Donor Coordination. JSI has extremely close relationships with UNFPA, one of its primary partners. The DELIVER Project worked with UNFPA in forecasting commodities for its specific districts, allowing a major contraceptive surplus to be donated as free contraceptives within the MOH. UNFPA and JSI Romania have worked together on many working groups, joint research/training and campaigns. JSI/Romania also works with UNICEF and World Bank, Swiss Cooperating Agency, and is in the process of developing a MOU between JSI and the Swiss Red Cross for the implementation of a pre/postnatal care program at the PHC level in selected districts.

RFHI is the only USAID-funded reproductive health initiative in Romania. JSI Romania has met with the USAID/Romania-funded Child Welfare Project managed by World Learning to examine areas of possible collaboration. Representatives of both projects attend the USAID SO team meetings and share their plans and progress. An area of potential collaboration would be to have RH training/youth sex education provided to the older orphaned children as well as train orphanage staff. World Leaning will share with JSI/Romania its mechanisms to manage a small grants program.

USAID/Romania has built on many of the past RH initiatives and projects previously funded by USAID prior to fall 2001, including the JSI TASC Project which worked in Romania in RH from 1999-2001.

RFHI through JSI/U.S. has actively sought information on new approaches or useful RH interventions that have been funded through other USAID projects, e.g. DELIVER, DRG Project, Georgetown University, and possibly in the future EngenderHealth and Family Health International. JSI/U.S. provides routine assistance to JSI/Romania on USAID best practices, technical publications, new strategies, etc. to keep them abreast of new programs and technical opportunities.

j. Data Collection/Results Dissemination
For the most part, the project IRs and indicators are appropriate however, as recommended in section III.b, JSI and USAID should review the expected project outcomes especially for the integrated package of RH services and come to agreement on them. The expected outcomes should be clearly defined and measurable. The M&E plan as stated is feasible and can be carried out with existing project resources but funding is not currently available to conduct a population-based survey, which would be the most appropriate and thorough methodology for assessing project impact.

- Identify sufficient funds to conduct a final population-based survey to measure coverage of RH services and changes in contraceptive behavior.

Additional indicators of quality of the services provided by family doctors would be ideal and could be obtained from a sample of supervision records when the new supervision system is implemented during the second half of the project. That would require shifting human resources to obtain these data and may not be cost-efficient. A small study of these data might be considered if time and human resources allow.

- JSI and USAID should discuss additional information needs and resource availability (human and financial) and determine priorities and resource allocations.

The approved M&E plan will be able to measure many project accomplishments but several team members are of the opinion that CYP, while useful for commodities management, is not the most appropriate proxy indicator for the contraceptive prevalence rate. CYP will reflect increasing or decreasing trends but does not accurately or adequately reflect new and continuing contraceptive users, contraceptive "drop outs" or users who switch methods. The number of women who adopt a contraceptive method postpartum is not captured nor is the number of women who have had abortions and are now FP users. Information about new and continuing users, drop outs, etc. is available at the clinic level in monthly service logs and client records but the providers do not use the information for client follow-up, quality improvement, or service management.

Whether project achievements in increasing CYP are also having the desired effect of lowering the abortion rate in Romania cannot be measured directly. Anecdotal reports from family doctors suggest that abortions are decreasing as family planning use increases but data are not available to substantiate those reports. In the past the abortion rate in Romania was calculated using a "correction factor" that assumed a certain amount of underreporting of abortions performed by private sector providers. That methodology is no longer valid: The GOR recently requested that private sector Ob/Gyns report the number of abortions performed to the DPHAs. Some doctors have complied with the request, most probably have not but there is no way to determine the number of abortions that have been reported and "correct" for unreported procedures. With little government oversight of private practitioners or established reporting procedures from the private to the public sector, reliably estimating the number of unreported abortions is virtually impossible using the past methodology.

- Determine feasible methodology to investigate and compile data on contraceptive service use and abortion, possibly supplementing with qualitative data to better understand attitudes and motivations about abortion.

RFHI has a communications plan that includes several approaches for disseminating project results:
- Electronic means: newsletter, discussion groups
- Printed means: newsletters (hard copies) and other publications
- Presentations: done at conferences or meetings for national and international audiences
- An end-of project dissemination conference

The project puts considerable effort into producing and disseminating materials that can be used by a variety of audiences. To date an extensive array of publications have been produced by RFHI and its partners including GOR Working Groups. Many of these documents are government policies, protocols, and guidelines which have been completed and produced during the past year. RFHI recently developed materials describing the implementation of the project's technical activities and success stories. These user-friendly materials should be useful within the RFHI partnership and Romania as well as to USAID and other Eastern European countries.

RFHI has clear ideas about products to be produced and disseminated at the EOP. RFHI and its partners are in the process of developing an outline of these products, defining the audiences and mechanisms for dissemination. Development of a project website is nearing completion. The web site will be linked to the sites of RFHI partners and donor organizations and will post program descriptions, interventions, success stories, publications and upcoming events/activities, etc. RFHI currently publishes a technical RH newsletter in collaboration with UNFPA, which is disseminated throughout Romania.

IV. CONCLUSIONS

The assessment team found that the RFHI project is on track to achieve its goals and does not recommend major changes in project objectives, strategies or activities. However, as noted, some clarifications as well as some revisions in project priorities would be beneficial.

RFHI has made significant progress toward the achievement of project objectives across the four IRs. Critical to the success of the project as a whole are several changes in national policy that authorized family doctors in PHC facilities to provide reproductive health services and that authorize insurance reimbursement for family planning and pre- and postnatal care services provide at the PHCs.

RFHI has developed several tools and approaches that have been successfully introduced and contributed to improved management, notably:

- The Logistics Management Information System (LMIS) for tracking distribution and consumption of supplies, and forecasting procurement needs;
- The "3 Pillars Approach" to services which integrates trained providers, available commodities, and BCC. The 3 Pillars Approach has been effective for ensuring that: 1) providers are trained in family planning; 2) trained providers have contraceptives to distribute; and 3) there is client demand for services.

Now in the second half of the project RFHI is about to undertake the next phase of training and service delivery roll-out for pre/postnatal care. Activities for the other RH components, e.g., STI/HIV/AIDS prevention, and breast and cervical cancer screening must be developed. At the same time current achievements in family planning must be strengthened, expanded and sustained.

There are several potential threats to continued expansion of family planning services for which RFHI is preparing:

- Decreased supply of free contraceptives;
- Stricter eligibility criteria for receipt of free contraceptives.

The competence and professionalism of the RFHI staff as well as their dedication and commitment to improving reproductive health care in Romania are the basis for the tremendous achievements of the project to date and will serve the project well in the remaining years.

ANNEX 1

QUESTIONS TO BE ADDRESSED BY THE TEAM
(Extracted from the Statement of Work)

The team members will, through interviews, data collection and review of the information sources, provide answers to questions including, but not limited to the following:

. I. PROJECT'S PROGRESS TOWARD PROJECT'S GOALS

- How realistic are the RFHI Project's overall goals?
- How effective is the project in achieving its goals?
- Would other activities be more appropriate to achieving program goals?
- How do the activities of the implementing partners fit into the RFHI "big picture"??

II. PROJECT DESIGN and IMPLEMENTATION

- Are planned activities appropriate for the accomplishment of the program objectives?
- Is the RFHI Project realistic, or is it too overly ambitious? Are there too many concepts to be implemented at once?
- Are there specific components of the program, e.g., interventions, models, tools, that lend themselves better to roll-out and replication?
- Are there key lessons learned or success stories that could form the basis for a balanced approach to dissemination nationwide and replication to other health programs (e.g. HIV/AIDS, TB, other health) or in other countries of the E&E region?
- Is the overall administrative and implementing structure to manage and carry out project objectives working effectively?
- How effective has the communication between the contractor and sub-contractors been?
- How effectively has USAID managed the RFHI project?

III. PROJECT IMPLEMENTATION ELEMENTS

SERVICE DELIVERY

- Are all relevant areas of service delivery being adequately supported? How can service delivery be further improved?

- What is the quality of service delivery? Clinical? Counseling? How is the quality being monitored and measured? How can service delivery be further improved?

- To what extent are family planning services (clinical and counseling) being integrated with pre-natal, postpartum and post-abortion care? How can these services be more integrated?

TRAINING

- Is the training of providers adequate? Is there "refresher" training?

- To what extent are trainers from the previous projects being used?

- Are data available on how the training has impacted service delivery?

BEHAVIOR CHANGE COMMUNICATION (BCC)

- Are BCC programs under the RFHI Project integrated with service delivery programs?

- Are the programs done in conjunction with the local officials?

- Will the materials that are being produced by the RFHI Project be replicable at a low cost in the future when USAID is no longer involved?

- What results have there been to date from the BCC activities? How is the impact being measured?

- Do all of the service sites in the target areas have adequate materials? Are plans being made for the materials to be distributed in other areas?

NGO INVOLVEMENT

- Have activities involved NGO counterparts for implementation?

FAMILY PLANNING

- How is the RFHI Project incorporating family planning into its programs?
- Does the program respond to the U.S. congressional interest in lowering the abortion rates in the E&E region? Should there be more emphasis in the program on reducing abortion rates?

- Do the programs adhere to USAID's *Guidance on the Definition and Use of the Child Survival and Health Programs Fund 2003* (with special attention to the chapters on family planning/RH, HIV/AIDS and maternal health)?

GENDER BALANCE/EQUITY

- Have the project's programming efforts focused on increasing male participation in its programs? How?

YOUTH

- What are the project's efforts towards reaching youth? Should USAID/Romania increase its assistance in the area of youth and reproductive health?

HOST GOVERNMENT INVOLVEMENT

- Is there high-level and local government support for the RFHI project?
- Is there close collaboration, decision-making and information sharing between the project's partners (MOH, USAID and contractors)?

COORDINATION WITH OTHER USAID PROJECTS AND OTHER DONORS

- How effective has the RFHI project been in coordinating with other reproductive health initiatives and with other donor organizations?
- How can such coordination be improved upon in the future?

. DATA COLLECTION/RESULTS DISSEMINATION

- Are the indicators and IRs appropriate and relevant to the project's work?
- Will the project's M&E plan adequately measure program accomplishments and goals?
- How should RFHI's programmatic results be disseminated to USAID and others working in international health?

ANNEX II
LIST OF CONTACTS

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Dr. Rodica Teodorolu, Integrated RH Services

PSI
Ms. Dawn Fess, Country Director

Society for Education on Contraception and Sexuality
Dr. Borbola Koo, Executive Director,
Dr. Violeta Horhoianu, Information Officer
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Ms. Rusu Monica – Logistic Manager, SECS
Dr. Constantinescu Angelica – Coordinator, Mociu Community Center
Mr.Gardan Viorica – Coordinator, Poieni Community Center
Dr. Toma Felicia – FP Center Coordinator, Dej
Ms. Valeria Albisi – FP Center nurse, Dej

Dr. Laura Hancu – General Practicioner, PHC SanPaul
Dr. Monica Morea – General Practicioner, PHC SanPaul

Dolj District
Dr. Stefan Popescu – Deputy Medical Director, DPHA Dolj
Dr. Ionut Beneduc – MCH Inspector, DPHA Dolj
Dr. Steliana Boian – MCH Inspector/Logistic Coordinator, DPHA Dolj
Dr. Narcisa Dinica – Health Promotion Inspector, DPHA Dolj
Dr. Mihaela Grigorescu – General Practitioner, Daneti
Dr. Sherif Tersunjaku – General Practitioner, Lipovu
Dr. Roxana Guna – General Practitioner, Lipovu
Dr. Doina Banicioiu – Craiova FP Cabinet/Trainer
Dr. Marcela Stefanescu – Craiova FP Cabinet/Trainer
Dr. Belu Alice, General Practitioner, PHC Comuna Galicea Mare
Dr. Anca Pitulico, General Practitioner, PHC Comuna Galicea Mare